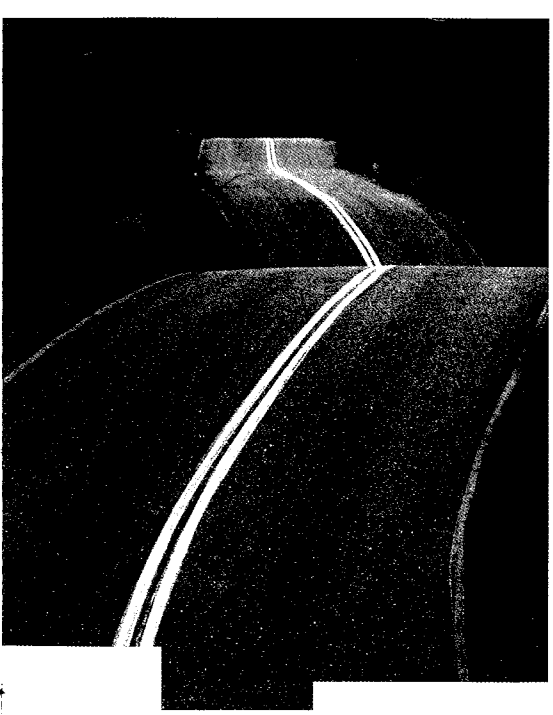
Why nurses are RESIGNING from rural and remote Queensland health facilities



This paper presents a selection of the results reported in the study "Factors Influencing the Recruitment and Retention of Rural and Remote Area Nurses in Queensland" (Hegney et al 2001). The main aim of this study was to determine why nurses in those rural and remote areas of Queensland that reported higher than State average turnover rates between February 1999 and May 2000, chose to leave their employment. The study therefore investigated the factors that influenced nurses' decisions to leave rural and remote area practice, the factors that influenced them to remain in practice and those factors nurses considered irrelevant to leaving or staying in rural/remote area nursing. This paper reports those factors the participants believed influenced them to leave rural and remote area nursing in Queensland. While the findings cannot be generalised to the Australian nursing workforce or to nurses not employed by Queensland Health, the study does confirm the findings of previous Australian research and formulates recommendations to assist future nursing workforce planning and policy.

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■ **Key Words**: rural nursing, remote area nursing, retention, leaving factors, management.

Introduction

Rural and remote area nurses comprise a significant proportion of the Australian nursing workforce. In 1996, 27% of a total of 171,684 registered nurses and 30% of a total of 46,488 enrolled nurses were employed in rural and remote areas (AIHW 1999). The rural and remote nursing workforce is predominantly female. The 1999 Ministerial Taskforce investigating nursing recruitment and retention in Queensland identified that 21 Health Service Districts across three zones (see Figure 1) had nursing workforce turnover rates greater than the State average turnover of 20.2% (Queensland Health 1999). Of these higher turnover districts, one had a nursing turnover greater than 50%, four greater than 30% and 15 greater than 20.2%. Eighteen of these Health Service Districts are in rural or remote areas.

There is considerable evidence to suggest that the factors influencing job satis-

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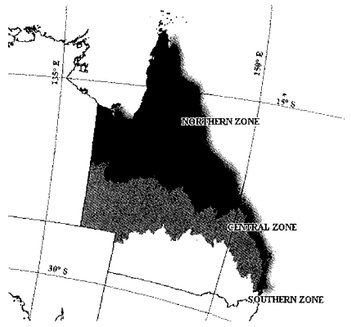
Figure 1: Queensland Health Service Zones



faction in rural and remote areas (and by inference, retention rates) differ markedly from those in metropolitan areas. It follows that retention strategies developed for metropolitan areas will not necessarily be applicable to rural and remote areas, because the demographics of rural nurses and their contexts of practice are not the same (Hegney et al 1997, Stephenson et al 1999).

For example, rural and remote area nurses are more likely to be women with family and social commitments in the region in which they work. They are also more likely to be working in these rural and remote areas because of a partner's employment commitments, rather than their own career trajectory (Stratton et al 1998). On a professional level, rural and remote area nurses have less access to other health professionals to complement their practice, and therefore often assume an expanded role for which they are often not vocationally prepared (Hegney et al 1997). It is common for rural and remote area nurses to express feelings of professional isolation and a lack of confidence with their expanded role, which is exacerbated by reduced access to further education and skill acquisition. They also have less exposure to a variety of specialist areas of practice that would consolidate their role as advanced generalists (Hegney & McCarthy 1999, Hegney & McCarthy 2000). Furthermore, the health care contexts and health care practices of rural and remote people are different to those of metropolitan populations (Hegney 1996) and require a different approach to nursing and overall health care.

The aim of this paper is to ascertain whether these factors characteristic of rural and remote area nursing practice contribute to the poor retention rate of the nursing workforce in these areas.

Method

A cross-sectional mail survey, which elicited both qualitative and quantitative data, was utilised to determine why nurses decided to leave or stay in rural/remote area nursing, with 'rurality' and 'remoteness' determined by way of the Accessibility/Remoteness Index for Australia (ARIA) (Department of Health and Aged Care 1999). The questionnaire contained four main sections; demographic information, work history, questions about rural and remote nursing, and the reasons for leaving or staying in rural or remote nursing. A fifth section elicited qualitative responses from participants regarding these issues.

The survey tool was rigorously peer reviewed, piloted and refined prior to dispatch to those permanently employed nurses who had resigned from the 18 rural and remote Queensland Health Service Districts experiencing a higher than State average turnover rate, from February 1999 to May 2000 (n=443). 146 participants returned completed questionnaires, which represents an overall return rate of 40%. Statistical data were analysed using SPSS version 9. Qualitative data were transcribed verbatim and categorised according to the emergent themes.

In order to capture the detail necessary for an in-depth understanding of the complex issues contributing to the retention of the nursing workforce, a large number of items were considered necessary for inclusion in the survey tool. Participants were therefore requested to indicate the degree of importance they placed on 91 separate factors that may have influenced their decision to leave rural and remote health services. A five point Likert scale contained the following possible responses: very important to leaving; important to leaving; not important to leaving or staying; important to staying; and very important to staying. It should be noted that the factors 'very important to leaving' and 'important to leaving' have been collapsed into the category 'important' due to the small numbers in some groups.

Data analysis

Due to the relatively few respondents and the large number of variables, it was not possible to undertake a factor analysis of survey items or to undertake statistical analyses more complex than simple descriptive tests such as frequencies and means. Where there were sufficient data to undertake chi-square analysis, however, this was performed to ascertain associations between variables.

Ethics

Ethical clearance for this project was obtained from the ethics committee of the University of Southern Queensland. An independent organisation (the Queensland Nursing Council) was utilised to manage the initial mailout of surveys, and the return of completed surveys to the project team. The project team therefore did not have access to any demographic data that could identify participants, so that the anonymity of participants was ensured and the confidential nature of their comments was protected.

Limitations of the research

It is acknowledged that the census frame is only representative of those nurses who have left publicly-funded Queensland Health facilities in the period from February 1999 to May 2000. Nurses who had left rural and remote nursing practice during this period but who were still employed by Queensland Health, or those employed by private health facilities, were not surveyed. The results obtained from this study may therefore not be generalisable to all nurses who left rural and remote area nursing in Queensland in that time period.

Results

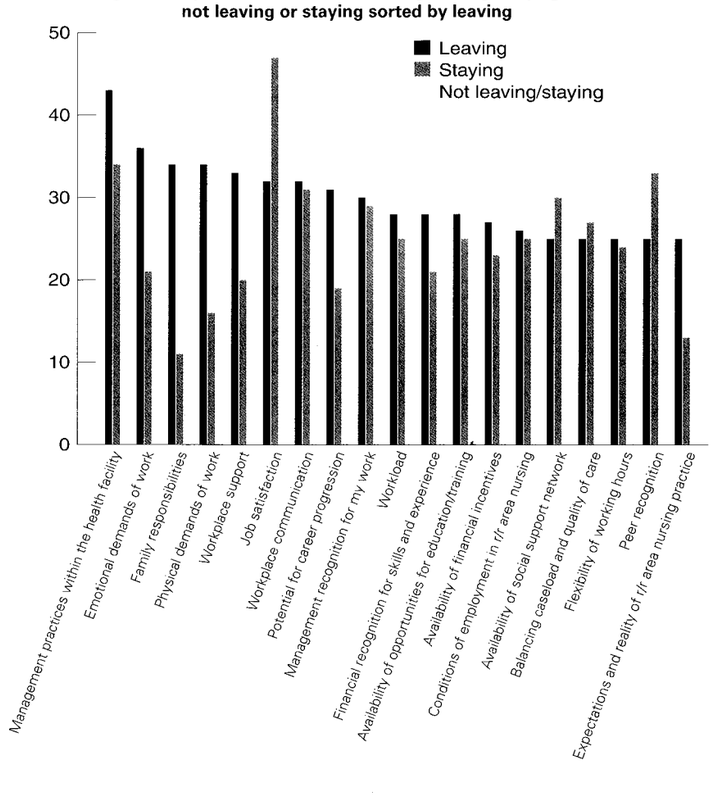
Factors influencing nurses' decisions to leave rural and remote practice

Figure 2 outlines the top 19 factors identified by participants as 'important to leaving'. Of these factors, only five factors ('management practices within the health facility'; 'emotional demands of work'; 'family responsibilities'; 'workplace communication'; and 'management recognition for my work') were more important to leaving than to staying, or not important to leaving or staying.

Management practices within the health facility

'Management practices within the health facility' were identified as the most significant determinant of leaving a Queensland Health service (43%). A number of sub-

Figure 2: Top 25% of factors influencing leaving, staying and not leaving or staying sorted by leaving



groups had a higher or lower percentage of responses to this factor, for example:

- Nurses with a higher response came from the following sub-groups. Those who: had been employed for less than 12 months (55%); were the 40-49 age group (55%); and had been employed in a health facility in ARIA 2 (52%) and ARIA 5 locations (53%).
- Nurses with a lower response rate came from the following sub-groups. Those who: were previously employed in ARIA 4 (33%) and ARIA 1 (37%) locations; had been employed part-time (36%); were aged 50 years and over (36%) and those 30-39 years of age (39%); and had been employed in the Southern Zone of Queensland Health (38%).

A number of other factors related to 'management practices within the health facility' are significant. For example, 'flexibility of working hours' (25%), 'working hours' (24%), 'level of remuneration' (22%), access to 'Time Off in Lieu' (TOIL) (21%) and 'availability of back-fill for leave' (21%) were identified as factors 'important to leaving' by the overall group. Visual inspection of the data highlights the following:

- Participants who were previously employed in a health facility in the Central Zone (29%); or in the age groups 30-39 (26%) and 40-49 (27%) ranked 'access to TOIL' marginally higher than nurses overall. However, nurses who have been employed in the Southern Zone (17%); were over 50 years of age (12%); were tertiary prepared (13%); and were previously employed in ARIA 3 health facilities (10%) were less likely to rank this as high as nurses in the study overall.
- The factor 'availability of back-fill for leave' was identified by 14% of nurses who had been employed in the Southern Zone; 12% of participants of 50 years of age; 10% of enrolled nurses; 14% of nurses who had been employed part-time; and 11% of nurses who had been employed in ARIA 1. In contrast, this factor was identified by more nurses who had been employed in ARIA 5 (37%) and ARIA 2 (30%) locations as important to leaving. These responses compared to a response of 21% by nurses overall in the study.
- 'Working hours' (24% overall) was identified by nurses who had been employed part-time (38%) as important to leaving. In contrast, nurses who had been employed full-time (17%) were less likely to identify this as a factor.
- 'Level of remuneration' (22%) was identified by 42% of nurses who had been employed in an ARIA 5 Health Service District. This contrasts with the 13% of participants from ARIA 1 health services who identified this as a factor important to leaving.
- Nurses who were aged 40-49 (36%) responded that 'flexibility of working hours' was important to leaving. In contrast, three percent (3%) of nurses over 50 years of age identified this as important to leaving. Similarly enrolled nurses (10%) were less likely to identify this as important to leaving.

Emotional demands of work

The 'emotional demands of work' (36%) were identified as a major determinant for resigning in this study. The sub-group variation most noticeable is the 53% of participants who had been employed in a health facility in an ARIA 5 location and the 52% of nurses who were aged 40-49. In contrast, nurses who had been employed in an ARIA 2 health facility (22%); were aged less than 30 years (26%); and had been employed for less that 12 months (27%) identified this as important to leaving at a lower rate than nurses overall (36%).

Workplace communication

Thirty two percent of the total participants rated workplace communication as related to leaving. The only sub-groups that did not rate this factor as the most significant were the participants who had been employed for less that 12 months (18%) and those previously employed in an ARIA 5 location (26%), both of which rated it as the second most significant.

Family responsibilities

Thirty-four percent of participants cited family reasons as being a factor in their decision to leave, making this the third most important factor overall. There are

Figure 3: Factors influencing leaving by Queensland Health Zone

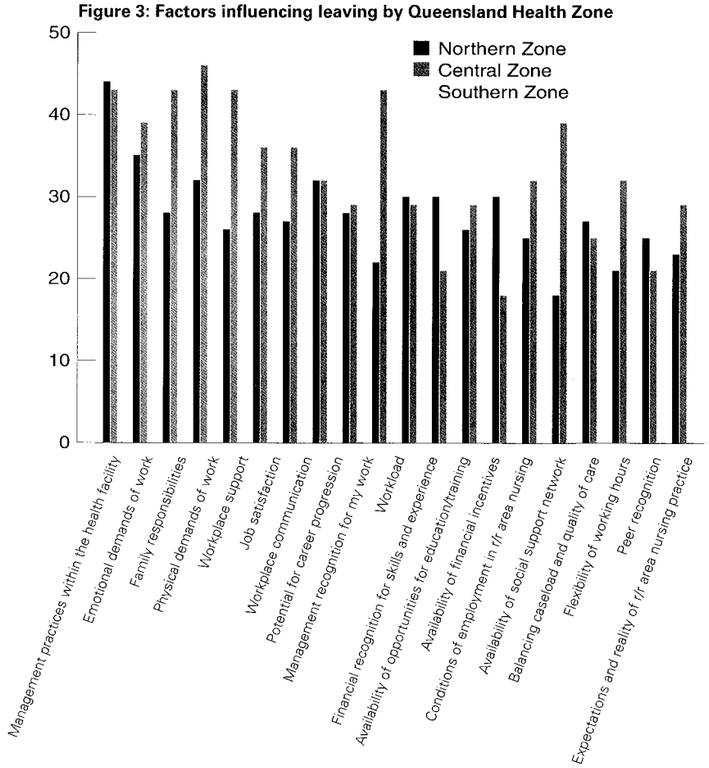
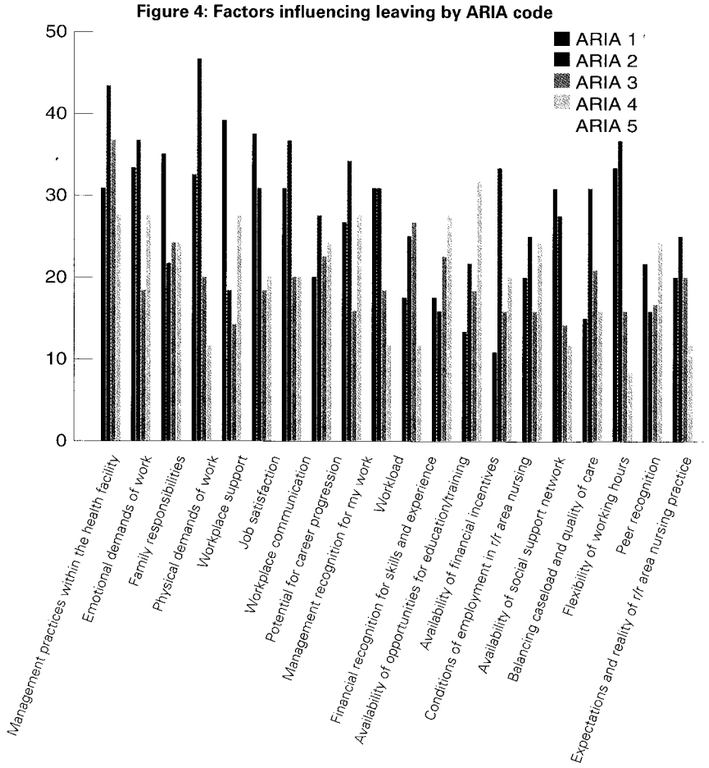


Figure 4: Factors influencing leaving by ARIA code



noticeable differences however between sub-groups, with nurses who were employed in the Central and Southern Zones; in the age group 30-49; hospital prepared; employed part-time; and in ARIA locations 1 and 4, rating family responsibilities highly. In contrast the nurses who were under 30 years of age and those who were tertiary prepared ranked this factor much lower (most of the under 30 age group were tertiary prepared, so there is a significant overlap between these groups).

Management recognition for my work

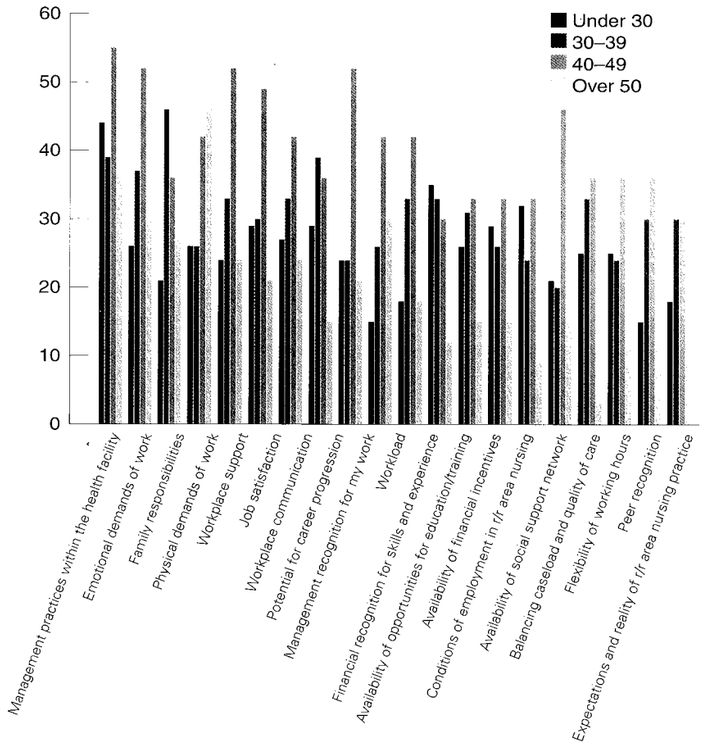
Thirty percent of participants in this study identified this as a factor important to leaving. Nurses who had been previously employed in an ARIA 2 health facility (41%) and enrolled nurses (40%) ranked this higher as a reason for leaving than nurses in the other sub-groups. In contrast, participants who had been employed for less than 12 months (18%); had been employed in an ARIA 3 locality (19%); and were aged 50 years and over (21%) responded to this factor as important to leaving less than nurses overall in this study.

Geographical location and its influence on leaving

It is apparent from the analysis of these results that geographical location (ARIA locality and Queensland Health Zone) influenced participants' decisions to leave (see Figures 3 and 4). For example, depending on place of previous work, there are differences among participants for the following factors:

- 'family responsibilities' (43% of nurses in the Central Zone and 41% of nurses in the Southern Zone indicated that this was an important reason in their decision to leave compared with only 28% in the Northern Zone);
- 'physical demands of work' (32% in the Northern Zone, 28% in the Southern Zone, compared with 46% in the Central Zone);
- 'workplace support' (26% in the Northern Zone, compared with 43% in the Central Zone and 41% in the Southern Zone);
- 'workload' (22% in the Northern Zone, 34% in the Southern Zone and 43 % in the Central Zone);
- 'conditions of employment' (30% in the Northern Zone as compared with 18% in the Central Zone and 21% in the Southern Zone);
- 'availability of social support' (25% in the Northern Zone, 32 % in the Central Zone and 17% in the Southern Zone).
- 'balancing caseload and quality of care (18% in the Northern Zone compared with 39% in the Central Zone and 31% in the Southern Zone);
- 'peer recognition' appears to become less important as the Accessibility and Remoteness Index increases (40% in ARIA 1, 44% in ARIA 2, 19% in ARIA 3, 10% in ARIA 4, and 0% in ARIA 5);
- 'the physical demands of work' (39% in ARIA 1, 56% in ARIA 2, 24% in ARIA 3, 14% in ARIA 4 and 37% in ARIA 5);
- 'the availability of financial incentives' becomes more important as the Accessibility and Remoteness Index increases (16% in ARIA 1, 26% in ARIA 2, 22% in ARIA 3, 38% in ARIA 4 and 47% in ARIA 5);
- 'workplace support' (47% in ARIA 1, 22% in ARIA 2, 17% in ARIA 3, 33% in ARIA 4 and 53% in ARIA 5).

Figure 5: Factors influencing leaving by age group

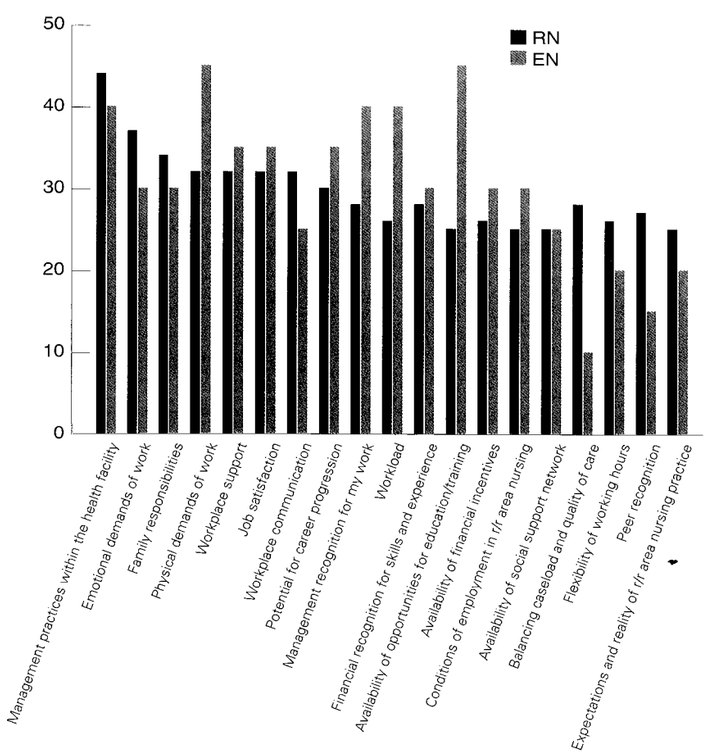


Age and its influence on decisions to leave rural and remote area nursing practice

Figure 5 demonstrates that the age of a nurse is also a major influencing factor on the decision to leave rural and remote area practice. For example:

- for 15 of the 19 overall top factors, more nurses in the age group 40-49 indicated that the factors were important in their decision to leave than nurses in any other age group. The factors where the difference between the 40-49 age group and all other age groups was particularly high include 'management practices within the health facility', 'emotional demands of work', 'workplace support', job satisfaction', 'workplace communication,' 'management recognition for my work', 'workload', 'financial recognition for skills and experience', 'balancing caseload and quality of care', and 'peer recognition'.
- for 13 of the top 19 factors, fewer nurses in the oldest (50+) age group cited them as important in their decision to leave. For example, factors which were rated particularly low for the 50+ age group were the potential for 'career progression within the health facility',

Figure 6: Factors influencing leaving by registered and enrolment status



'availability of opportunities for education and training', 'availability of financial incentives', 'conditions of employment in rural/remote area nursing', 'availability of social support network', 'flexibility of working hours' and 'peer recognition'. In contrast, the factor that was rated high for this group was the 'physical demands of work'.

Registration or enrolment status and its impact on decision to leave rural and remote area nursing practice

Figure 6 compares the percentages of registered and enrolled nurses by the overall top 19 factors that were important in their decision to leave rural or remote practice. For 14 of these factors, the differences between these two groups were non-existent or minimal. Obvious differences are evident in the following factors: 'physical demands of work', 'management recognition for my work', 'workload', and 'availability of opportunities for education and training', which were issues for a higher percentage of enrolled nurses than registered nurses. In relation to the factors of 'flexibility of working hours' and 'expectations and reality of rural and remote area nursing practice', a higher percentage of registered nurses cited these as important factors in their decision to leave.

In summary, the major determinants of nursing retention in this cohort of nurses include management practices, such as flexible rostering, leave arrangements, communication practices and management recognition for the work performed. Congruent with the literature that emphasises the importance of the rural and remote context of practice, local issues must also be accommodated. For example, there are zonal differences reported in this data, as well as differences related to the degree of remoteness. The emotional demands of rural and remote area nursing, and concurrent family responsibilities, should also be accounted for when planning for the nursing workforce in these areas.

Discussion

Demographics

The predominance of the 30-39 age group in this study is consistent with the AIHW data that indicate that 31% of the registered and enrolled nurses in Queensland were in this age group in 1996 (AIHW 1999). Further, the findings from the Ministerial Taskforce: Nursing Recruitment and Retention Report suggested that the average age of enrolled nurses was 37.4 years and 36.6 years for registered nurses (Queensland Health 1999). The participants in this study are similar to these average ages. The participant's gender proportions were similar to the Queensland Nursing Council's 2001 registrations and enrolments, which indicate that 91.34% of the nursing workforce are female and 8.66% are male. The finding that the majority of nurses in this study had completed their schooling in a non-metropolitan area is consistent with previous studies that suggested that health professionals who have a rural/remote upbringing are more likely to work in a rural area (Kamien & Buttfield 1990, Hayes et al 1993, Hegney et al 1997). The data did suggest that the geographical location of the first nursing qualification influenced decisions to work in rural and remote area nursing.

These data indicate that the rural and remote area nursing workforce is ageing, remains a female dominated profession and is largely sourced from rural or remote areas. It is essential, therefore, that retention strategies target this demographic in the rural and remote sector. Strategies could include, for example, family-friendly work practices and flexible rostering. The success of nursing scholarship schemes in regional areas of the US (Kimmel 1991, Meyer et al 1991) may well be duplicated in Queensland. Such a scholarship scheme would allow the more mature students who predominate in rural and remote areas to undertake studies in rural nursing, without a HECS burden, effectively bonding them to the health system and preventing further untimely attrition.

The proportion of full-time and part-time nurses in this study contrasts with the Hegney et al (1997) study, in which approximately 52% of nurses had been employed part-time. These findings are also congruent with other studies by Harris (1992), Donnelly (1993), Blue (1993), and Buckley and Gray (1993). It is important to note that this cohort were full time employees of Queensland Health. If it had been possible to include nurses who were employed on a temporary or casual basis in this study, a different picture may have emerged.

Factors influencing leaving

These results highlight the importance of work related factors and the way these influence the decisions of nurses to leave rural and remote area nursing in Queensland. Despite the inherent altruistic motivation of many rural nurses, it appears that working conditions and management practices within government health facilities, which have been cited in other studies, are the most significant factors influencing nurses to leave the workforce (Queensland Health 1999, NSW Health 2001). That these issues have been repeatedly reported by other researchers over the last decade, indicates that health departments are largely ignoring the voice of nurses at the coalface and key stakeholders within the nursing profession (National Rural Health Alliance 2001).

These data suggest that there are discrete groups of participants who have different reasons for leaving rural and remote practice in Queensland. For example, those nurses who had left employment prior to completing 12 months within the health service, particularly recent nursing graduates, appear to have different reasons for leaving than those who have been employed in the workforce longer. It is apparent from this study that the first 12 months of a nurse's employment are a critical time, and that more resources should be directed towards this group if it is to remain in rural and remote area nursing. The high attrition rate in the first year of rural and remote practice may be related to the lack of rural and remote area practicum available to students prior to graduation and the culture shock they experience once they enter the nursing workforce (Hegney et al 1997). There are a greater percentage of undergraduate and postgraduate nursing courses now designed for the rural and remote context, and the traditional barriers students had experienced in accessing these courses are slowly being eroded. For example Queensland Health has introduced scholarships for undergraduate students who wish to undertake a rural and remote nursing career (Queensland Health 2001a). In comparison to medicine however, nursing remains disadvantaged in terms of the amount of money available and the number of scholarships offered to attract and retain nursing graduates in rural and remote areas (Hegney et al 2001).

While this study is limited because of the small number of newly graduated nurses in this category, the findings about this group do offer some insights into the issues for them. This is not the only study to find there is a lack of peer networking and mentor arrangements to support these nurses once they graduate (NHRA 2001). It is increasingly apparent that nursing is disadvantaged in terms of postgraduate peer networks and postgraduate education support, although the Transition Support Scheme currently being introduced in Queensland may ameliorate this to some extent (Queensland Health 2001b).

In contrast to other studies, the lack of opportunities for further education and training for nurses generally was only identified by 28% of the nurses in this study. It should be noted, however that 73% of nurses who had been employed for less that 12 months and 53% of nurses employed in ARIA 5 Health Service Districts did identify this as a significant reason for leaving. For these nurses, the frustration they experienced from wanting to attend courses, but not being able to because of the expense to the organisation, and the non-availability of back-fill, was very strongly expressed in the qualitative data. Further, 35 participants noted that they wanted formal recognition of the post-registration knowledge and skills they had earned, and said that extra qualifications were worthless in terms of workplace recognition and adequate remuneration. Congruent with several other reports, they believed that a revised nursing career structure should be introduced (NSW Health 1996, Queensland Health 1999, NSW Health 2001, NRHA 2001). In addition to providing an avenue for career progression that is currently lacking in non-metropolitan areas (Hegney et al 1997), this would compensate for the expense and hard work necessary to acquire advanced skills and qualifications for rural and remote practice.

Those nurses who worked in the most remote areas also identified different reasons for leaving. The majority of these were related to their isolation, despite having access to remote area nursing incentives in their industrial award. These participants indicate that they need incentives comparable to those available to other health professionals, including travel and education subsidies, better accommodation, access to vehicles, and email/internet facilities.

The other group of nurses who appear to have different reasons for leaving employment within Queensland Health are those aged over 50. In particular, factors such as the health of the family and personal health reasons influenced these nurses to leave. Family responsibilities and proximity to significant others have also been identified in previous studies as major determinants of retention of the nursing workforce (Stratton et al 1998, Stephenson et al 1999, NSW Health 2001). This further reinforces the findings of the Ministerial Taskforce into Recruitment and Retention in Queensland (Queensland Health 1999), which strongly recommended the introduction of family friendly rostering, greater flexibility in workplace practices and more equitable leave arrangements for nurses, in order that they may fulfil their family responsibilities with minimum impact upon their workplace.

Conclusion

Whilst acknowledging that this study has been carried out in Queensland with a particular group of rural and remote area nurses (those who had left Queensland Health), and that the findings cannot be generalised fully to Queensland or the Australian workforce, the study has confirmed findings from several other reports. There is a wealth of data now available to the Commonwealth, State and Territory governments as a result of this and other studies with regard to the factors that influence the retention of nurses in rural and remote areas. There is little evidence that the recommendations have been heeded by government health departments; or that the few recommendations that have been acknowledged have been implemented and evaluated in a cohesive manner. It is the hope of the project team that the report from which this paper is derived will contribute to workforce planning strategies that are relevant for rural and remote nurses and that enhance their career prospects.

Acknowledgements

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